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| **E:\:HSE Logo.jpg** | | | | | | | | | | MEATH PRIMARY CARE TEAMS REFERRAL FORM **Please ensure ALL relevant sections are complete & consent received from Client, Parent/Guardian**  **(Reviewed September 2018)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Please return to:**  HSE, Dublin NE,  Laytown Health Centre,  Laytown, Co Meath.  A92 VA03  Tel: 041 9827012 Fax: 041 9820180  e-mail: [**eastmeath.referrals@hse.ie**](mailto:eastmeath.referrals@hse.ie) | | | | | | | | | | | | |
| **Tick box for Service(s) you are referring to:**  *(Please note copies of this referral form will be forwarded to all selected disciplines)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nutrition & Dietetics  Occupational Therapy  PHN/CRGN  Physiotherapy  Psychology  Primary Care Social Work  Speech and Language Therapy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **S**urn**ame:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **First name:** | | | | | | | | | | | | | | | | | | | | **Card Type** GMS  DVC  LTI  Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Known As:** | | | | | | | | | | | | | | | | | | | | **Card Number:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Gender:** Male  Female | | | | | | | | | | | | | | | | | | | | **DOB** | | | | | | | | | | *(date/month/year)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address:**  **Post Code:** | | | | | | | | | | | | | | | | | | | | **Email address** *(optional)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Consent to receive:**  **Emails** YES  NO  **Text Messages** YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone:**  **Mobile:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Contact Person** *(if required)* | | | | | | | | | | | | | | | | | | | | **Relationship to client:** | | | | | | | | | | | | | | | | | | | | | | | | | | **Contact Number:** | | | | | | | | | | | | |
| **Interpretive services required** YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Which language?** | | | | | | | | | | | | | | | | | | | | | | |
| **Pre-school/School** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Class** | | | | | | | | | | | | | | | | | | | | | | |
| **GP Name/Practice** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Contact Number for GP** | | | | | | | | | | | | | | | | | | | | | | |
| **Hospital discharge date (if applicable)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Hospital** | | | | | | | | | | | | | | | | | | | | | | |
| **Diagnosis / Medical History** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Reason for Referral *(please be specific)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CONSENT:** Some child & adolescent referrals require the signed consent of **BOTH** parents/guardians. In this instance the form may be returned to you for a second signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Has the client/parent consented to this referral? Yes**   **No**  (must be completed for Adults & Children) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Has the client/parent consented to sharing of information? Yes**   **No**  (must be completed for Adults & Children) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **I/We consent to the referral of (insert name of child):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of Parent/Guardian:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Contact No. & Address:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of Parent/Guardian:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Contact No. & Address:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **REFERRER** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Title:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Contact No.:** | | | | | | | | | | | | | | | | | | | | **Email:** | | | | | | | | | |
| **Signature:**       **Date:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Preferred Method of Contact: Post**  **Telephone/Mobile**  **Email** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Clinical Assessment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Existing pressure sore** | | | | | | | | | | | | | **Yes**   **No** | | | | | | | | | | | | | | | | **Stage** 1  2  3  4 | | | | | | | | | | | | | | | | | | | | **Water-low score** | | | | | | | | | |
| **Assessments** | | | | | | | | | | | | | **Barthel score** /20 | | | | | | | | | | | | | | | | **MMSE score** /30 | | | | | | | | | | | | | | | | | | | | **EPDS** score /30 | | | | | | | | | |
| **Please note the service(s) involved in client's care** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adult Intellectual Disability | | | | | | | | | | | | |  | | Enable Ireland | | | | | | | | | | | | | | | | | Elderly Day Centre/Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CAMHS | | | | | | | | | | | | |  | | Family Support | | | | | | | | | | | | | | | | | Physical & Sensory Disability | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Children’s Disability Service (6-18) | | | | | | | | | | | | |  | | Palliative Care | | | | | | | | | | | | | | | | | Adult Mental Health Service | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Social** *(Complete where appropriate)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Living Alone** YES  NO  Home Support YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Social Situation** | | | | **Mobility** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other relevant information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Client Name:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **DOB:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PLEASE COMPLETE FOR THE RELEVANT DISCIPLINE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **NUTRITION & DIETETICS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Malnutrition (must score >2) | | | | | | | | | | | | | Enteral Feeding | | | | | | | | | | | | | | | | Dysphagia – Has client been referred to SLT? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | |
| Coeliac Disease | | | | | | | | | | | | | Irritable Bowel Syndrome | | | | | | | | | | | | | | | | Inflammatory Bowel Disease | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Pre-diabetes | | | | | | | | | | | | | Obesity | | | | | | | | | | | | | | | | Type 2 Diabetes – referred to structured patient education? | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | |
| Hyperlipidaemia | | | | | | | | | | | | | Hypertension | | | | | | | | | | | | | | | | Other (please specify) | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| **Paediatric Growth Charts & relevant bloods must be supplied** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Coeliac Disease | | | | | | | | | | | | | | | | | | Overweight (BMI > 91st Percentile) | | | | | | | | | | | | | | | | | | | | | | Iron Deficiency Anaemia | | | | | | | | | | | | | | | | | | |
| Constipation | | | | | | | | | | | | | | | | | | Fussy eating for > 6 months (Group Session) | | | | | | | | | | | | | | | | | | | | | | Other (please specify) | | | | | | | | | | | | | | | | | | |
| **OCCUPATIONAL THERAPY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Difficulties with activities of daily living - please specify. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Difficulties with transfers - please specify. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Seating/Positioning  Pressure care  Wheelchair assessment: occasional user  full time user | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other Relevant Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PHN/CRGN** *Attach Any Other Relevant Reports or Information* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Continence problem | | | | | | | |  | | | | Day Care | | | | | | | | | | | | | | | |  | | | | | | Nursing assessment | | | | | | | | | | | | | | | |  | | Psychological Support | | | | | | |
| Chronic Illness Management | | | | | | | |  | | | | Home Supports | | | | | | | | | | | | | | | |  | | | | | | Respite | | | | | | | | | | | | | | | |  | | Other (specify) | | | | | | |
| Health Education/Promotion | | | | | | | |  | | | | Leg ulcer/pressure care/wound care | | | | | | | | | | | | | | | |  | | | | | | Preventive/Anticipatory Care | | | | | | | | | | | | | | | |  | |  | | | | | | |
| **CHILD HEALTH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Audiology - Date of Test** | | | | | | | | | | | | | | | | **Type of Hearing Test** | | | | | | | | | | | | | | | | | | | | | | **Outcome**  *(please attach report)* | | | | | | | | | | | | | | | | | | | | |
| Tick if you are concerned about any of the following: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vision |  | | Weight | | | | | | | | | | |  | | | | | Height | | |  | | | | | | | | | Nutrition | | | | | | |  | | | | | Hearing | | | | | | | | | |  | | | | | |
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| **PHYSIOTHERAPY** *Attach copies of reports of X-rays, MRI, DEXA scans, etc if available* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relevant Investigations/Results: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How long has the client had complaint? | | | | | | | | | | | | | | | | | 1-2 Weeks | | | | | | |  | 2-4 Weeks | | | | | | | | | |  | | 1-3 Months | | | | | | |  | | | | 3-6 Months | | | | | |  | 6+ Months | | |  |
| Is there a history of falls in the last six months | | | | | | | | | | | | | | | | | YES  NO | | | | | | | | | | | | | | | | | | | | Night pain: | | | | | | | | YES  NO | | | | | | | | | | | | | |
| Is the client experiencing difficulty with | | | | | | | | | | | | | | | | | transferring | | | | | | | | | |  | | | | | | walking | | | | | |  | | Unable to work as a result of the condition | | | | | | | | | | | | | | | |  | |
| **CHILD PSYCHOLOGY** *Tick as appropriate and provide brief details* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anxiety | | | | | | |  | | | | Bed Wetting/Soiling | | | | | | | | | |  | | | Behavioural Difficulties | | | | | | | | | | | | | | | | |  | | General Emotional Difficulties | | | | | | | | | | | | | | |  |
| Query ADHD | | | | | | |  | | | | Sleeping Difficulties | | | | | | | | | |  | | | Suicidal Ideation | | | | | | | | | | | | | | | | |  | | Abuse (specify type) | | | | | | | | | | | | | | |  |
| Deliberate Self-harm | | | | | | |  | | | | Depression | | | | | | | | | |  | | | Eating Difficulties | | | | | | | | | | | | | | | | |  | | Child in Care | | | | | | | | | | | | | YES  NO | | |
| Additional Comments: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SOCIAL WORK SERVICE** *Reason for Referral* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **SPEECH & LANGUAGE THERAPY** *Tick as appropriate* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Children’s Services** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Non-Talker | |  | | | | Immature Pronunciation | | | | | | | | | | | | | | | | |  | | | Stammer/Fluency Problems | | | | | | | | | | | | | | | | | | | | |  | | | | Hoarseness/voice concerns | | | | | | |  |
| Delayed language | | | | |  | | | | At what age did the child use first words? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Use two-three words together? | | | | | | | | | | | | | | | | |
| Feeding Difficulties | | | | | Hearing Difficulties | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Adult Services** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Speech Assessment  Language Assessment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe the client’s presentation: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Swallow Assessment:  Please state current diet / route of nutrition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| **FAILURE TO COMPLETE THE SECTION FOR CONSENT WILL RESULT IN - THE FORM BEING RETURNED TO THE REFERRER** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |